St. Clair County Community Mental Health

Organization Application

Network Enrollment and Credentialing

Complete as a new Organization or when re-applying.

Current Privileging Status:	**Applying For:**
○ Provisional ○ Probationary ○ Full ○ N/A	○ Provisional ○ Full ○ Re-Privileging (Term shall be determined by Privileging & Credentialing Committee)

Section I. Organizational Profile

Sections I-V to be completed by the organization applying for networking enrollment both initially and at the time of re-application.

Organization Name: _____

DBA: *(if applicable)* _____

Group Affiliation: *(if applicable)* _____

NPI Number of Primary Location: _____ Organization Web Address: _____

Primary Mailing Address: _____

Primary Physical Address: _____

Primary Phone #: _____ Fax #: _____ Hours of Operation: _____

Primary Point of Contact Name: _____

Contact Phone #:_____ Contact Email: _____

Organization is Accepting New Beneficiaries: ○ Yes ○ No

Facility is ADA Compliant: ○ Yes* ○ No

*If yes, please specify if the office/facility has the following equipment to accommodate individuals with physical disabilities: ☐ Wheelchair(s) ☐ Ramp(s) ☐ Elevator(s) ☐ Accessible Bathroom(s)

☐ Other: (specify) _____

Specific Linguistic Capabilities within your Agency: ☐ ASL ☐ Language Interpretation Services ☐ Non-English Languages*

*If your organization maintains any Non-English languages spoken, please specify those:

_____

Specific Cultural Competencies within your agency: ☐ Sexual Orientation ☐ Gender Competency ☐ Age-Specific ☐ Race ☐ Religious/Spiritual Beliefs ☐ Ethnic Background(s)*

*If your organization maintains specific Ethnic Background competencies, please specify those:

_____

Staff have completed Cultural Competency Training: ○ Yes ○ No

Mental Health Providers Only:

Independent PCP Facilitator(s): _____

***Note:** If the organization has contracts for multiple locations, please provide an additional page to this applicable with all the above information included for each location. An NPI number is required for each location.

Section II. Organizational Licensing and Certification

Accreditation Type: ☐ N/A ☐ TJC ☐ CARF ☐ COA ☐ ACHC ☐ NCQA ☐ Other: (specify) _____

Note: You must provide the organization's accreditation letter(s), accreditation report(s), and any accreditation corrective action plan(s), as well as the status of the action plan(s).

Organization Type: ○ For Profit ○ Not for Profit ○ Partnership ○ Private ○ Public ○ Government
○ Limited Liability Corp. (LLC) ○ Other: (specify) _____

Certification and Licensing: *(check all that apply)*

☐ MDHHS Certification if the organization is not accredited Expiration Date: _____

☐ MDHHS Certification Waived if accredited Expiration Date: _____

☐ MDHHS Certification Pending Expiration Date: _____

☐ MDHHS Designated Women's Specialty Service Provider

☐ LARA Licensure Obtained *(specify below)*

License Type: _____ Expiration Date: _____

☐ LARA Licensed Integrated Treatment Provider Expiration Date: _____

☐ MDHHS ASAM Level of Care (LOC) Designation(s) (List all MDHHS LOC Designations)

ASAM LOC: _____ ☐ Adult ☐ Children Expiration Date: _____

ASAM LOC: _____ ☐ Adult ☐ Children Expiration Date: _____

ASAM LOC: _____ ☐ Adult ☐ Children Expiration Date: _____

Note: If the organization has additional certifications, licenses, and/or ASAM LOC Designations, please include this information on an additional page. Copies of all licenses and/or certifications are to be submitted with this application as well.

Section III. Organizational Managing Employees

Instructions: List all Managing Employees that exercise operational or managerial control over, or who directly or indirectly conduct the day-to-day operations of the Provider Entity. Include the name, phone number, email, and job title for each individual.

Name	Phone #	Email	Job Title

(Attach additional sheet(s) as necessary)

Section IV. Organizational State and Federal Regulatory Status Attestation

This organization is in good standing with all State Regulatory bodies: ○ Yes ○ No*
*If no, provide a written explanation on a separate page.

This organization is in good standing with all Federal Regulatory bodies: ○ Yes ○ No*
*If no, provide a written explanation on a separate page.

This organization has active Federal or State sanctions: ○ Yes* ○ No
*If yes, provide a written explanation on a separate page.

This organization has active Federal or State disbarments: ○ Yes* ○ No
*If yes, provide a written explanation on a separate page.

This organization has had a malpractice lawsuit and/or judgment within the last ten (10) years: ○ Yes* ○ No
*If yes, provide a written explanation on a separate page.

This organization has been excluded from Medicare/Medicaid participation: ○ Yes* ○ No
*If yes, provide a written explanation on a separate page.

This organization maintains liability insurance: ○ Yes* ○ No
*If yes, provide a copy with the submission of this application.

I attest that I have completed and attached the Region 10 PHIP Conflict of Interest form: ○ Yes* ○ No**
*If yes, provide a copy with the submission of this application.
**If no, provide a written explanation below.

_____

Section V. Provider Services

Instructions: Indicate the service(s) you are requesting privileges to provide within your organization under subcontract for St. Clair County Community Mental Health within the scope of your practice.

Contract Provider: Please indicate all items that apply within **tables A-D.**

A. Mental Health Services – Contracted Provider	
☐ Assertive Community Treatment (ACT)	☐ Integrated Dual Disorder Treatment (IDDT) (Fidelity Tested)
☐ Applied Behavior Analysis (ABA)	☐ Medication Administration
☐ Assessment and Evaluation	☐ Medication Review
☐ Behavioral Management Review	☐ Nursing Facility Mental Health Monitoring
☐ Child Therapy	☐ Occupational Therapy (OT)
☐ Clubhouse Psychosocial Rehabilitation Program	☐ Outpatient Partial Hospitalization
☐ Community Psychiatric Inpatient	☐ Peer-Directed & Operated Support Services
☐ Community Living Supports (CLS)	☐ Personal Care in Specialized Residential Settings
☐ Crisis Interventions	☐ Personal Emergency Response System (PERS)
☐ Crisis Observation Care	☐ Physical Therapy (PT)
☐ Crisis Residential Services	☐ Prevention Services
☐ Dialectic Behavior Therapy (DBT) (Certified Team)	☐ Respite Care
☐ Electroconvulsive Therapy	☐ Skill Building Assistance
☐ Enhanced Medical Equipment and Supplies	☐ Speech, Hearing, and Language
☐ Enhanced Pharmacy	☐ Supported Employment
☐ Environmental Modifications	☐ Supports Coordination
☐ Family Therapy	☐ Targeted Case Management
☐ Family Training	☐ Transportation

Continued on next page →

A. Mental Health Services – Contracted Provider (cont.)	
☐ Treatment Planning	☐ Fiscal Intermediary
☐ Wraparound Facilitation	☐ Health Services
☐ Telemedicine	☐ Home Based Services
☐ Housing Assistance	☐ Individual/Group Therapy
☐ Inpatient Psychiatric Hospital – State Facility Admission	
B. Habilitation Support Services	
☐ Assistive Technology	☐ Out of Home Pre-Vocational Services
☐ Community Living Supports (CLS)	☐ Personal Emergency Response System (PERS)
☐ Enhanced Medical Equipment and Supplies	☐ Private Duty Nursing (PDN)
☐ Enhanced Pharmacy	☐ Respite Care
☐ Environmental Modifications	☐ Supported Employment
☐ Family Training	☐ Supports Coordination
☐ Out of Home Non-Vocational Habilitation	
C. Children's Services	
☐ Assessments	☐ Home Care Training, Non-Family
☐ Behavioral Management Review	☐ Individual/Group Therapy
☐ Community Living Supports (CLS)	☐ Massage Therapy
☐ Environmental Modifications	☐ Medication Review
☐ Family Therapy	☐ Occupational Therapy (OT)
☐ Family Training	☐ Non-Family Training
☐ Health Services	☐ Respite Care
☐ Targeted Case Management	
D. Serious Emotional Disturbance Services	
☐ Community Living Supports (CLS)	☐ Child Therapeutic Foster Care
☐ Family Home Care Training	☐ Therapeutic Overnight Camp
☐ Family Support Training	☐ Transitional Services
☐ Therapeutic Activities	☐ Wraparound Services
☐ Respite Care	☐ Home Care Training – Non-Family
☐ Youth Peer Support	
E. Substance Use Disorder Services	
☐ Recovery Housing	☐ Peer Delivered Services (Recovery Coaching)
☐ Early Intervention Services	☐ Residential Services
☐ Individual Assessment Services	☐ Sub-Acute Detoxification Services
☐ Medication Assisted Treatment Services	☐ Outpatient Care Services
☐ Women's Specialty Services*	☐ Psychiatric Services
☐ Gender Competent Services*	☐ Adolescent Treatment Services
☐ Intensive Outpatient	

*SUD Women's Specialty and Gender Competent Services must meet criteria specified in Region 10's policy SUD Women's Specialty Services and Gender Competent Programs (#05-03-06).

Attestation:

The signature below indicates that the statement and indications made in Sections I-IV are accurate and true. The signature below is that of an authorized representative within your organization.

Print Name: _____ Job Title: _____

Signature: _____ Date: _____

Section VI. Review and Recommendation

This section is to be completed by a SCCCMH Network Manager or a Designee.

I have reviewed the application as well as documents submitted by the organization. I, or a designee, have done a due diligence review of all information and find the statements submitted by the organization to be true and accurate.

○ Yes ○ No *If no, note area(s) of concern that have been identified on a separate piece of paper and attach to application.*

After review of this information, I recommend:

○ Full Privileges
○ Probationary Privileges*
○ Limitations of Services Requested
○ Privileges be Revoked/Denied*

***If privileges are being revoked, denied, or placed on probationary status, attach a separate document to the application that outlines the rationale for the decision.**

I recommend the following terms: *(if applicable)*

Start Date: _____ Expiration Date: _____

Network Manager/Designee Signature: _____

Print Name: _____ Date: _____

Section VII. Privileging & Credentialing Committee Review and Recommendation

This section is to be completed by the Privileging & Credentialing Committee or a Designee.

After review of the organization's application, the Privileging & Credentialing (P&C) Committee recommends:

○ Full Privileges
○ Provisional Privileges*
○ Probationary Privileges*
○ Limitations of Services Requested
○ Privileges be Revoked/Denied*

***If privileges are being revoked, denied, or placed on provisional/probationary status, attach a separate document to the application that outlines the rationale for the decision.**

Recommended Term: Start Date: _____ to _____

P&C Committee/Designee Signature: _____

Print Name: _____ Date: _____

Chief Clinical Officer Approval: ☐